Blueprint for Health
Request for Proposals
Vermont Department of Health

APPLICANT INFORMATION SHEET

Applicant Organization: _____

Project Director/Coordinator: _____

Mailing Address: _____

Town, State, Zip Code: _____

Telephone: _____ Fax #: _____

e-mail Address: _____

Federal Tax ID Number: _____

Total Amount Requested: _____

Grant Period: From: July 1, 2006 – June 31, 2007

Who should we call if we have questions about this application?

Name: _____ **Phone #:** _____

**NOTE: This information sheet should be presented as the cover sheet of the application submitted. Be sure to include all information requested.

SECTION 1 – GENERAL INFORMATION

Introduction and Background

The Vermont Blueprint for Health Chronic Care Initiative (Blueprint) was launched in 2003 as a component of Governor James Douglas's package of health care reforms. The Blueprint is led by a unique public-private partnership that includes health care providers, health insurance plans, professional organizations, community and non-profit groups, consumers, businesses, and state government.

Chronic conditions are the leading cause of illness, disability, and death in Vermont. More than half of all Vermont adults have one or more chronic conditions that can be expected to last a year or more, limit what they are able to do, and/or require ongoing medical care. Driven by the combination of an aging population, increased prevalence of obesity, and lifestyle habits such as poor nutrition, physical inactivity, and tobacco use, the needs of Vermonters with chronic conditions will be the primary driver of the demand for health care and the resulting costs for the foreseeable future. The burden of chronic disease is both personal and financial: caring for Vermonters with chronic conditions consumes more than three-quarters of the $2.8 billion spent in Vermont each year on health care and clearly affects one's quality of life.

The Blueprint articulates a clear vision for Vermont: Vermont will have a statewide system of care that improves the lives of individuals with and at risk for chronic conditions.

The overarching goals for the Blueprint are that:

- The quality of care for Vermonters with chronic conditions will improve.
- The quality of life for Vermonters with chronic conditions will improve.
- The cost of caring for Vermonters with chronic conditions will moderate.

To achieve its vision, the Blueprint will:

- Utilize the Chronic Care Model[1] as the framework for system change;
- Utilize a public-private partnership to facilitate and ensure sustainability of the new system of care;
- Facilitate alignment of Blueprint priorities and projects with other statewide health care reform initiatives

The Blueprint approach calls for fundamental change in the health system at every level to help patients and health care providers effectively manage and

[1] For more information on the Chronic Care Model, go to www.improvingchroniccare.org

prevent chronic disease. Innovations in five broad areas will be utilized as part of this effort:

- patient self-management
- provider practice
- community activation and support
- information systems
- health system design

The Blueprint's strategic approach will be implemented on two levels:

1. *Statewide initiatives* to plan and build consensus among stakeholders, identify and spread best practices, build the infrastructure to support a redesigned system of care, and align incentives for sustainability. Work on health system design occurs at this level.

2. *Community-focused initiatives* to support changes in approach to chronic care delivery with provider practices, patient self-management, community activation and support systems, and information technology. Each of these efforts, as well as the synergistic effect of concurrent implementation, will be evaluated at the local Hospital Service Area (HSA) level.

Initial implementation was carried out through community-based pilots in two Hospital Service Areas (HSAs), Bennington and St. Johnsbury, and focused on diabetes. As the model is refined, the Blueprint will spread incrementally over five years to include additional chronic diseases and to encompass every HSA in the state.

This RFP solicits proposals from eligible organizations to implement the *community-focused initiatives* referenced above, that are critical to successful implementation of the Blueprint.

Eligibility

Any general hospital licensed in Vermont may apply. Only one eligible organization in each Hospital Service Area will be funded. However, funded applicants may subcontract with partner agencies with prior notification to and approval by VDH. Applicants must have met the February 6, 2006 deadline for submitting a letter of intent to apply for grant funding and must have received notice of acceptance of the letter from the Department of Health before submitting an application.

Forms and Assistance

For any assistance or information about the grant process for the Vermont Blueprint for Health grants, applicants should contact:

Eileen Girling RN, MPH
Director, Vermont Blueprint for Health
Vermont Department of Health
PO Box 70
Burlington, VT 05402
(802) 865-7705
egirlin@vdh.state.vt.us

Electronic application forms can be downloaded at www.healthyvermonters.info

Submission and Deadlines

Applicants are required to attend an applicant training on February 23, 2006 to receive important information and assistance in the grant process.

The application narrative should be no longer than 15 double-spaced pages, with one inch margins and 12-point font. Short attachments that are relevant to the narrative may be included but should be kept to a minimum. Pages should be numbered and attachments should be clearly labeled. Applications that do not follow these guidelines will be returned for resubmission.

Applications are due on or before 4:30 pm, April 12, 2006. Applications will be considered "on time" if they are received on or before the established deadline date. Electronic applications will be accepted if followed by a hard copy as outlined above. Faxes will not be accepted. Late applications will not be accepted for review and will be returned to the applicant. The unstapled original and six (6) securely stapled 2 sided copies should be sent to:

Eileen Girling RN, MPH
Director, Vermont Blueprint for Health
Vermont Department of Health
PO Box 70
Burlington, VT 05402

Grant Limit and Use of Grant Funds

Funding levels will vary based on the size and participation level of the HSAs receiving the award, as well as based on availability of state or other financial appropriations for FY 2007. However, funding is anticipated to be available for new communities in the range of $75,000 to $300,000 per hospital service area. An eligible organization may apply for funding for a one year grant period. Applicants are encouraged, however, to think in terms of a three-year project period. Year one applicants will focus on diabetes with new conditions added

yearly as outlined in the Strategic Plan[2]. However, there is no guarantee that funds will be available in the future.

A portion of grant funds may be used for staff salaries and consultant fees, with the majority of funds directly supporting implementation and operating expenses, and indirect costs associated with the proposed program activities. Technical assistance will be available to grantees through Blueprint and VDH staff.

Grant Period

The grant funding period is July 1, 2006 through June 30, 2007.

Grant Review and Award Process

The Vermont Department of Health and representatives of the Blueprint Executive Committee will review proposals. The Vermont Department of Health reserves the right to reject and not score any application that does not comply with the mandatory eligibility requirements. It also reserves the right to reject any and all applications after they have been reviewed, to negotiate awards after the application process and to accept applications deemed most favorable to the interest of the State of Vermont and goals of the Blueprint chronic care initiative.

The points assigned to each category are as follows:

Category	Points
1. Program Narrative	
a. HSA description	5
b. HSA resources and needs	5
c. HSA capacity to implement workplan	25
d. Workplan	
1. Self-management education	15
2. Community activation and support	15
3. Information technology	15
4. Provider practice	15
e. Evaluation plan	5
2. Budget	The budget will not be scored
Total	100

[2] The Blueprint Strategic Plan can be found on the Vermont Department of Health's website at www.healthyvermonters.info

Grantee Requirements

Grants will require a total match of 25% toward the project, with a minimum of 10% of the total match being a financial match, and the remaining as in-kind. Local, state and federal funds can be used as match. Grantees must provide a letter of commitment describing the specific financial and in-kind contributions that are being made to the proposed project. All items listed in the budget for the purpose of showing the required 25% in-kind and financial match should have a corresponding letter of commitment from the CEO or head of the organization.

Grantees will be required to participate in at least one in person review meeting during the grant cycle. Additional phone meetings will be scheduled to monitor and support project roll out and implementation requirements. The in person meetings will likely coincide with the mid point of the reporting period and will be used to review the progress to date. Blueprint staff and/or consultants may also require periodic local meetings with the designated project manager and local team members.

Reporting and Monitoring

Grantees will submit specific information on each component of this grant using a reporting form supplied by the state and supplemented by a written narrative. Reporting frequency will be quarterly.

SECTION 2 – APPLICATION INSTRUCTIONS

1. Program Narrative (not more than 15 pages)

Provide a concise and complete description of your proposed approach to Blueprint implementation, being sure to include all the parts described below. Your proposal must address all four components of the Blueprint for Health listed below:

- self-management
- community activation and support
- provider practice
- information technology

a. Hospital Service Area description

Give a brief description of your hospital service area – its name, geographic boundaries, relevant demographic information, etc.

b. Hospital Service Area resources and needs

Rates of chronic disease – What do the data tell you about the prevalence and costs of chronic disease in your area, especially diabetes? How does your area compare with other areas in Vermont?

Community assessment - What are the particular issues that contribute to increasing chronic disease rates in your area? Geography, inaccessible services and resources, community norms are possible areas to consider. Describe the positive elements in your area that could help residents choose healthy lifestyles. Which elements do you need the most help with? Who are the key players in your community, and how can they coordinate existing efforts to fill gaps in service or strengthen support networks? Is there anything unique about your community that impacts chronic disease rates? Include data secured from local HRAP survey data regarding community perception of needs.

c. Hospital Service Area capacity to implement workplan

Describe your health care system and its strengths. Please highlight your successes in providing community-based services and supports. What elements – services and support – does your health care system bring to the table? What financial resources? Please include a **maximum of three** letters from major partner organizations stating their level of commitment to the Blueprint chronic care initiative (for example: hospital priority for provider practices to participate; IT resources already in place and able to receive automated data feeds; financial support, in-kind support, use of space, and/or equipment, referrals, etc.). Also include a letter of support from the District Director of your local Department of Health office. They can help you assess the viability of proposed activities and may be able to offer you data and information from other planning initiatives in the Department that may assist you with your application. (See Attachment A for a list of District Health Office Directors.) You should also use this section to describe how you will sustain the work begun with this grant funding beyond the one year budget period.

d. Workplan

Your workplan must address all four components of the Blueprint for Health as described below. Specific goals, objectives and activities should be included in your plan and align with goals and objectives outlined in the Blueprint strategic plan. Be sure to include activities and objectives that are measurable within the budget cycle (July 1, 2006 – June 30, 2007) as well as those that are long range strategic goals. Please use the template included as Attachment B to complete your workplan. All elements should be simultaneously available to participating provider practices once they are in the implementation phase.

1. *Goals and objectives.* This section should include the overall purpose of the plan and how it addresses the following overarching Blueprint goals:

   - The quality of care for Vermonters with chronic conditions will improve.
   - The quality of life for Vermonters with chronic conditions will improve.
   - The cost of caring for Vermonters with chronic conditions will moderate

   The goal(s) should be the final outcomes you desire and align with Blueprint goals. Projected outcomes of your activities form the basis of **objectives**. This differentiates objectives from methods or activities. The operant verb in an objective should indicate measure (increase, decrease, etc.) rather than project activity (to offer, establish, develop, run, etc.). The objectives state the outcome of the project that will move the community toward realizing the stated goal.

   Each outcome objective should:

   - Include an end date by when change will occur
   - Use "increase" or "decrease" or other measurable language
   - Identify a specific target population to be addressed
   - Include the behavior, attitude, condition, or knowledge to be changed
   - Identify specific data sources to be used to measure change

   An example of an objective is: By 2010, increase the number of Healthier Living Workshops[3] offered to at least 4 times per year in each of the HSAs with at least 75 sessions offered statewide, as measured by workshop attendance sheets.

2. *Activities:* In this section, describe how you plan to reach your goal(s) and objectives. Using information from your needs and resources section and the applicant training, describe the following:

   - The strategies/programs you intend to use
   - The settings in which you plan to use these strategies/programs
   - A timeline for completion which lists each objective you plan to accomplish in meeting your goal(s) and which align with Blueprint goals
   - Who will be responsible for implementing the strategies/programs

   This section should clearly demonstrate that your strategies and programs are logically related to your goal(s) and objectives. This section should also

[3] The Healthier Living Workshop is the name used in Vermont for the Stanford University Chronic Disease Self-Management Program. http://patienteducation.stanford.edu/programs/cdsmp.html

include plans for continuation of the Chronic Care Model and specific interventions funded through this grant award, after the initial funding expires.

Component 1: Self-management education

Vermonters with chronic conditions spend most of their time functioning outside the health care system, in their homes or workplaces. Self-management is the cornerstone of day-to-day care for all chronic conditions Good self-managers can be cultivated through appropriate services and programs.

Goal: Vermonters with chronic conditions will be effective managers of their own health**.**

- Identify a local leader to be the liaison with VDH self-management staff for development, implementation, local coordination and evaluation of the Healthier Living Workshop for your HSA (required for funding).
- Explain how you will engage and coordinate with local ADA recognized programs and CDEs to facilitate cross referral opportunities.
- Describe how you will ensure that the Healthier Living Workshop is offered in multiple communities within your HSA.
- Describe how you will work with participating physician practices and other community partners to identify at least 6 people to be trained to lead the Healthier Living Workshops.
- Describe how you will work with participating providers and other community partners to recruit participants – including an initial focus on those with diabetes - to the Healthier Living Workshops.
- Describe other initiatives you want to undertake to improve self-management skills of those with a chronic condition.

Component 2: Community activation and support

There are few communities in Vermont in which citizens, health professionals, businesses, and public and private organizations engage in effective partnerships to promote the health of all community members. Community programs and resources are not well linked to the health care delivery system. Provider practices are often unaware of local community resources for their patients who are in need of referrals. Physical inactivity and obesity are risk factors for many chronic diseases and are among the leading “real” causes of mortality.

Goal: Vermonters will live in communities that support healthy lifestyles and offer opportunities to prevent and manage chronic conditions.

The Blueprint chronic care initiative will focus community based resources on improving physical activity levels for individuals with or at risk for chronic

conditions. The initiative should focus on adults over 18 with or at risk for chronic conditions however, could include children if they are part of a larger, adult focused initiative. Communities will implement programs and share information on the availability of services that support a healthier lifestyle. Walking programs have been demonstrated to have a positive effect on health and should be the first program developed in the community. Vermont 211 will be the primary means of sharing information about these and other services. Successful communities must use a combination of approaches including social support as well as policy and environmental changes as outlined below. See Attachment D for additional physical activity resources.

SOCIAL SUPPORT INTERVENTION (your program must include this strategy)

Strategies that change behavior through building, strengthening or maintaining social networks that provide supportive relationships for increasing and sustaining physical activity and improving diets are considered social support interventions.

Grantees should use *Get Moving Vermont* as a model for their community based walking program. (*Get Moving Vermont* materials can be found at healthvermont.gov/fitandhealthy after February 15, 2006). Grantees must:

- Identify a local leader to manage the community physical activity programs and link to the Department of Health.
- Create an outreach or marketing strategy to promote the walking program and other local physical activity programs that includes populating the 211 system.

Below are examples of social support programs. Describe how you will use some of these methods to enhance your program.

- Walking groups or clubs that provide friendship and support
- Buddy systems, using friends or encouraging family partnerships for walking, i.e parents and children, spouses or partners, grandparent and grandchild to use each other for support and encouragement
- Establishing a program for individuals “contracting” with another person (friend or family member) to complete specified levels of physical activity daily or weekly.

In addition, grantees may establish and/or expand community based programs designed for those with chronic conditions, such as strength building programs, swimming or other exercise programs for the elderly. Emphasis should be placed on programs that are evidence based or built on promising practices that have been shown to demonstrate behavior change.

Describe how you will measure the effects of your strategy.

Your program must also include one or both of the strategies described below*:*

ENVIRONMENTAL APPROACH

Strategies that create or enhance access to places for people to be physically active are considered environmental approaches. They require an assessment of the community's physical environment in terms of accessibility for physical activity and healthy eating for people with chronic conditions. *Environmental approaches must include outreach activities to raise public awareness about their existence and encourage their use.*

- Describe how you will improve the physical environment in your community to make it more conducive for physical activity. Examples include:
    - improving lighting and safety along sidewalks and bike routes
    - improving sidewalk and trail maintenance
    - creating buffers between pedestrians and motor vehicles, such as planting trees or shrubs
    - providing areas to secure bicycles near shopping areas, workplaces and other public or private buildings.

Other examples of environmental strategies grantees may implement include the following:

- Mapping out neighborhood walking trails or paths and installing mile markers along the way.
- Enhancing or creating places for community members to be physically active, such as:
    - creating or improving local playgrounds
    - making public stairwells accessible, well ventilated, well-lit, safe and clean, with clear signs leading people to the stairwells;
    - creating access to public spaces such as schools or malls during "off hours" to be used for walking.
- Mapping out the proximity of places to be active in different areas of town, i.e. show that there is a place to be active within one or two miles of every housing community or of a major resource that most people use, such as a school or grocery store

Describe how you will measure the impact of your intervention.

Consider using the results of VDH's "*Inventory of Resources Related to Health for Cities and Towns*"[4].

[4] VDH Obesity Prevention Program's "Inventory of Vermont Cities and Towns" is a report on the results of a survey that was conducted of the "built environment" for every city and town in the state. This report can be used for creating or improving access to places for physical activity, available February 2006.

POLICY APPROACH

Strategies that effect regulations or legislation in order to create or enhance access to places for people to be physically active are policy approaches. *Policy approaches must include outreach activities to raise public awareness about their existence and encourage their use.*

Examples of policy approaches follow. Please describe a policy approach you will take and how it will be implemented and accomplished.

- Work with constituents, partners, and town planners to improve, create, and/or build facilities such as walking trails, side walks, bike paths or other facilities to improve the public's ability to increase physical activity in their every day lives.
- Encourage mixed use zoning with homes situated within walking and bicycle riding distance of attractive, walker friendly commercial areas.
- Pass ordinances stipulating the type of street lighting necessary to improve safety along streets, paths and in parking garages.
- Work with law enforcement to increase enforcement of speed limits to make communities safer for biking and walking.
- Work with law enforcement to establish and enforce safety regulations or laws such as bicycle helmet use regulations, conduct safety workshops for parents and children, and provide incentives for complying with safety regulations.
- Improve street sidewalk and street-crossing safety routes to schools in order to encourage and allow students to walk or bike to school on a regular basis.
- Establish traffic calming measures such as lower speed limits or stop lights in high pedestrian areas (commercial areas, schools, playgrounds).

Describe how you will measure the effect of these policy changes.

Component 3: Information Technology

To provide effective care, health care providers need clinical and demographic data to monitor patient needs and support clinical decisions. Provider practices do not routinely have access to information systems that support proactive, planned care for their patients with chronic conditions. Information systems are not routinely integrated and aligned to facilitate sharing of data sources. Confidentiality and security requirements pose significant challenges to developing secure data exchanges between provider practices as well as with laboratories, insurers, hospitals, and pharmacies.

Goal: Vermont will have a Chronic Care Information System (CCIS) that supports statewide implementation of the Blueprint chronic care initiative for both individual and population-based care management.

- Identify a local IT lead to assist Blueprint IT staff with technology requirements for receiving automated data feeds into the local EMR and the Vermont Health Record (VHR) registry application for diabetes and cardiovascular disease .
- Explain how you will facilitate provider engagement and implementation of the VHR or a system with equivalent functionality, to proactively identify and manage individuals with diabetes, and track clinical results.
- Explain how the information technology system(s) in your hospital service area (i.e. predominant EMR or Patient Management System) will interface with the VHR application.

Component 4: Provider Practice

The current acute care model is poorly adapted to the needs of individuals with chronic illnesses. This can lead to inefficiency, fragmentation, and additional cost to both the patient and the health system. Few provider practices in Vermont currently are aware of or utilize the framework of the Chronic Care Model to care for their patients with chronic illness.

Goal: The proportion of patients receiving care consistent with evidence-based standards will increase**.**

- Identify a local provider champion to assist with provider recruitment, training and participation in the CCM.
- Describe how you will recruit 75% of provider practices and coordinate local training requirements for participating providers/practices.
- Describe how you will identify one local resource to be the expert in the Blueprint strategy and implementation requirements for participating practices.
- Explain how you will support provider practices to offset their costs of implementation. Provider support may include practice payments to cover the cost for personnel to be trained, staff to support data input to populate the registry, and/or implementation of new office systems. (The Blueprint will contract directly with faculty to provide the local training.)
- Describe how you will ensure that information about the Healthier Living Workshops and ADA Diabetes Self-Management Education (including referral and registration procedures), as well as community physical activity programs are available in each participating office.

e. Evaluation Plan

The purpose of evaluating a program or strategy is to determine what effect the program, initiative or activity has had, what worked well and why and what can be improved. All elements of the local strategy should be available to participating providers (i.e. every effort should be made to have Healthier Living Workshops available in areas served by participating providers).

There are two types of evaluation data we would like you to include in your evaluation plan:

Process evaluation describes what you did as compared with what you planned to do. Process evaluation answers the following questions:

What was done? How frequently? How was it done? How many participants? When? Did we reach the participants we planned to reach? Did we deliver the quantity and quality of services we planned to deliver? Were the resources we put into the project sufficient to carry out the planned activities?

This information will be a valuable tool for identifying and correcting problems or omissions in design and implementation of the project before they negatively impact the project.

Outcome evaluation is concerned with measuring the effect of a project or strategy on the participants. An outcome evaluation is a method for assessing the short and long term effects of a program or strategy and addresses the "so what" reply that follows process evaluation. The outcome objectives will have specified indicators of change in attitude, behavior, knowledge, or condition, describing a change from the "before" situation to the "after" situation. Year one clinical changes should relate to diabetic patients.

Please describe your plan for collecting, analyzing and using the data.

2. Budget

Applicants must submit a budget using the budget form in Attachment C. Your budget must also include a narrative, which should justify the specific items listed in the budget.

Expenditures of grant funds must adhere to the specific line items in the grantee's approved budget. Indirect costs cannot exceed 10% of the total approved annual grant award. Transfers among operating line items (increases and decreases) in excess of 10% of the total approved grant award are permitted only with the express written consent of the Department for Health.

VERMONT DEPARMENT OF HEALTH DISTRICT OFFICE DIRECTORS

The district director of your local Department of Health office can help you assess the viability of proposed activities. He/she may be able to offer you data and information from other planning initiatives in the Department that may assist you with your application.

Barre
Jeff Hunsberger, District Director
VT Dept. of Health
McFarland Office Building
5 Perry Street, Suite 250
Barre, VT 05641-4272

1-888-253-8786
1-802-479-4200
FAX: 479-4230

Bennington
Marcia Russo, District Director
VT Dept. of Health
200 Veterans Memorial Drive, Suite #1
Bennington, VT 05201-1944

1-800-637-7347
1-802-447-3531
FAX: 447-6910

Brattleboro
Fran deFlorio, District Director
VT Dept. of Health
232 Main Street, Ste 3
Brattleboro, VT 05301-2881

1-888-253-8805
1802-257-2880
FAX: 254-6360

Burlington
Nancy Menard, District Director
VT Dept. of Health Burl. D.O.
1193 North Avenue, Suite #1
Burlington, VT 05401-2749

1-888-253-8803
1-802-863-7323
FAX: 863-7571

Middlebury
Moira Cook, District Director
VT Dept. of Health
700 Exchange Street, Suite 101
Middlebury, VT 05753-1529

1-888-253-8804
1-802-388-4644
FAX: 388-4610

Morrisville
Linda North, District Director
VT Dept. of Health
63 Professional Drive
Morrisville, VT 05661

1-888-253-8798
1-802-888-7447
FAX: 888-2576

Newport
Ann Creaven, District Director
VT Dept. of Health
100 Main Street, Suite 220
Newport, VT 05855

1-800-952-2945
1-802-334-6707
FAX: 334-3904

Rutland
Mary Lou Bolt, District Director
VT Dept. of Health
300 Asa Bloomer State Office Bldg.
Rutland, VT 05701

1-888-253-8802
1-802-786-5811
FAX: 786-5984

St. Albans
Judy Ashley-McLaughlin, District Director
VT Dept. of Health
20 Houghton Street Suite 312
St. Albans, VT 05478-2248

1-888-253-8801
1-802-524-7970
FAX: 527-5405

St. Johnsbury
Darlene Ahrens, District Director
VT Dept. of Health
67 Eastern Avenue, Suite 1
St. Johnsbury, VT 05819-2638

1-800-952-2936
1-802-748-5151
FAX: 751-3229

Springfield
Rebecca Thomas, District Director
VT Dept. of Health
100 Mineral Street, Suite 104
Springfield, VT 05156

1-888-296-8151
1-802-885-5778
FAX: 885-3707

White River Junction
Margaret Caudill-Slosberg, District Director
VT Dept. of Health
226 Holiday Drive, Suite 22
White River Junction, VT 05001

1-888-253-8799
1-802-295-8820
FAX: 295-8832

Goal:

Annual outcome objective:				
Long-term outcome objective:				
Target group:				
Activities		**Lead role**	**Time line**	**Evaluation indicators**

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	Blueprint for Health Request for Proposals Budget template				
Applicant Organization:					
Financial Information Sheet					
For 7/1/06-6/30/07					
		Blueprint Funding	**Other Funding**	**In-Kind Support**	**Total**
PERSONNEL:					
FRINGE BENEFITS;					
TRAVEL:					
EQUIPMENT:					
SUPPLIES:					
CONTRACTUAL/ CONSULTANT					
OTHER:					
TOTAL DIRECT CHARGES:					
INDIRECT CHARGES					
TOTALS :					

Recommended Physical Activity Resources

- Physical activity recommendations:

General population:

Get Moving Vermont healthvermont.gov/fitandhealthy (available after February 15, 2006)

http://www.cdc.gov/nccdphp/dnpa/physical/recommendations/index.htm

Older Adults:

http://www.cdc.gov/nccdphp/dnpa/physical/recommendations/older_adults.htm

- The Guide to Community Preventive Services (Community Guide) report: Increasing Physical Activity. See CDC's summary of the report. Pay particular attention to the following "strongly recommended" interventions: "social support interventions", and "creating or improving access to places for physical activity combined with informational outreach". http://www.cdc.gov/nccdphp/dnpa/physical/recommendations.htm

- Learning to Live Well with Diabetes pages on exercise: http://www.healthyvermonters.info/hi/diabetes/pubs/learning/exercise.shtml
  Note that while this publication follows similar guidelines advising people to check with their health care providers before beginning an exercise program, USDHHS documents that regular physical activity, fitness, and exercise are critically important for the health and well-being of people of all ages. The President's Council on Physical Fitness and Sports implies that initiation of moderate exercise is safe, and far greater risks are presented by habitual inactivity. Along with USDHHS they state that physical inactivity poses health risks that are almost as high as cigarette smoking, hypertension and high cholesterol.

- http://fitness.gov/physical_activity_fact_sheet.html

- Chronic Care Model-- http://www.improvingchroniccare.org/change/model/components.html

- A program from Maine that is a good example of a community-based walking program using social support
  www.movemore.org